ASSEMBLY BILL (AB) 74 COUNTY WELFARE DEPARTMENT FAMILY STABILIZATION (FS) PLAN

COUNTY WELFARE DEPARTMENT (CWD):		DATE:	
	CWD CONT	ACT INFORMATION	
NAME/POSITION:	CWD CONTA	CT INFORMATION	
ADDRESS:			
PHONE NUMBER:	EMAIL ADDRESS:		
nine categories. There is an ac will accept up to 1,000 charact	Iditional text box to enter ot ers of text. If more space is y also attach any material	cated for the FS Program and include responses to the follow her information about your FS program if needed. The text both is needed you may also submit attachments to accommodate is that address each of the areas below if the materials can (i.e. not scanned copies).	xes the
Please indicate the date your 0	CWD will begin offering an F	⁻ S program:	
What types of services will be	provided under the FS prog	 ram?	
Homelessness			
☐ Mental Health			
Substance Abuse			
☐ Domestic Violence			
Other, please list			
How will clients be informed of	the FS program?		
How will clients be able to requ	ıest participation in the FS μ	orogram?	
How will the county determine	which clients will be selected	ed for the FS program?	

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How will the county notify the clients that are participating in the FS program?
How often will county staff contact FS families?
How will FS Intensive Case Management differ from general Case Management?
What types of partnerships will you develop for your FS Program? (i.e. Community based organizations, non-profits, etc.)
What strategies will you use to link clients with these providers?
What strategies does your CWD have to transition clients to WTW?
How does the FS program compliment or enhance your current services?

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Please include any other components of your FS program not covered above:	
Please fill out this form electronically and submit to FSProgram@dss.ca.gov	

Note: CWDs must submit their plans no later than 30 days after implementation of their FS Programs. CDSS may request subsequent submittals of AB 74 FS Plans from CWDs depending on the needs of the program.

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